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AUGUSTA MEDICAL CTR SKILLED CA	78 MEDICAL CENTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 11/15/16 through 11/17/16. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 17 certified bed facility was 10 at the time of the survey. The survey sample consisted of four current Resident reviews (Residents # 1 through 4) and one closed record review (Resident # 5).	F 000	**F 167 Right to survey results** 1) After the surveyor reported on 11/16/16 that the results were not easily identifiable, a large bold notice (72 Font) was added to the bulletin board on 11/16/16 to identify the location of survey results. Of note, the most recent survey results were posted and accessible, however, there was not a notice indicating that they were the results. 2) All ten residents on the unit may have been affected by not having a posted notice indicating the location of the most recent survey results. As mentioned, this was corrected the day the deficiency was pointed out. Of note, all residents are given a packet of information on admission which contains the following statement- "A copy of the most recent Long Term Care survey results is posted on the bulletin board across from the nurse's station". 3) All residents upon admission will continue to receive the admission packet identifying the location of the survey results. Additionally, the 2016 survey results were placed in a notebook labeled "State Survey Results" and attached to bulletin board on 11/29/16. A new dry erase board has been ordered and will be publicly displayed across from the nurse's station by 12/9/16. This dry erase board has a notice at the bottom that states "The results of the most recent survey conducted by Federal or State surveyors and any plan of correction is available on the bulletin board beside this notice".	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to post the location of the most recent survey results, and failed to clearly identify the results, which were found posted on a bulletin board. The findings were:	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Debra Alderman Director Quality 12.8.2016

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F 167	Continued From page 1 During the General Observations tour of the facility at 2:45 p.m. on 11/16/16, a sheaf of papers was found tacked to a bulletin board across from the Nurses Station. The top page of the papers was a cover letter from the Virginia Department of Health indicating that the accompanying papers were the most recent survey results. There was no signage on the bulletin board to identify the papers as the survey results, and there was no way to identify the papers as the survey results without reading the cover letter. There was also no signage in the immediate vicinity of the Nurses Station, nor any where else on the nursing unit, to advise of the availability and location of the most recent survey results. The survey results, including the signage and location, were discussed with the Skilled Nursing Director and the survey team during a meeting at 4:20 p.m. on 11/16/16.	F 167	4) Starting 12/5/2016 the charge nurse will check daily to ensure the most recent results are posted in the appropriate location under the appropriate sign on the bulletin board. She will initial on a daily checklist that the results are posted. This checklist will continue for 45 days and will be monitored weekly by the director of nursing or his designee to ensure compliance. The director of nursing will be responsible for posting the plan of correction from the 2016 survey results, once approved by the Virginia Department of Health. **Correction date: ~~11/16/16~~** 11/17/16 aw	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to offer	F 309	**F 309 Provide care/services for highest wellbeing (non-pharm)** 1) Nursing staff was made aware of the deficient practice on 11/17/16 with further follow-up planned at staff meetings. Resident #1 had no adverse effect from deficient practice as he continued to be awake, alert and ambulating up to 500 feet. 2) Nine residents had received pain medications and could have been affected by the deficient practice. 3) During staff meetings on November 29 & 30, 2016, staff was educated on providing non-pharmacologic interventions as part of the nursing care plan. The director of nursing is working with information systems department to edit the pain assessment to make documentation of non-pharmacologic interventions more accessible. This edit will be in place by December 23, 2016.	

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F 309	Continued From page 2	F 309	4) Beginning December 26, 2016, the director of nursing or his designee will audit ten resident charts per month for two months confirming that non-pharmacologic interventions have been implemented and documented. If non-compliance is noted, an additional month of ten resident chart audits will be conducted. **Correction date: December 23, 2016**	

non-pharmacological interventions to address pain control for one of ten residents in the survey sample, Resident #1.

Resident #1 was administered Ultram or Tylenol 17 times during the dates of 10/17/2016 through 11/15/2016 for complaints of pain. Use of non-pharmacologic interventions was implemented only three (3) times according to documentation in the EMR (electronic medical record).

Findings included:

Resident #1 was admitted to the facility on 10/17/2016 with diagnoses including, but not limited to: Pancreatitis, Malnutrition, Hypoalbuminemia, Placement of a PEG tube (feeding tube), Diabetes and Congestive Heart Failure.

The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 10/24/2016. Resident #1 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #1's electronic medical record was reviewed on 11/15/2016 at approximately 12:00 p.m. Documentation in the record included where this resident had received Ultram 25mg (milligrams) by mouth a total of six times and had received Tylenol 650mg by mouth a total of eleven times for various complaints of pain since his admission on 10/17/2016.

Subsequent review of Resident #1's CCP (comprehensive care plan) included a plan for pain with interventions that included,

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F 309	Continued From page 3 ..."non-pharmacological interventions..." The DON (director of nursing) was interviewed at 3:45 p.m. regarding non-pharmacological interventions and where this would be documented in the EMR. The DON stated, "Let me research a little bit and see what information you all have access to in the medical record. The DON approached the conference room on 11/16/2016 at approximately 9:30 a.m. with a paper copy of what the nurse's see in the EMR when documenting pain and interventions. The DON stated, "This is what the nurses see when they document pain. It has an area here for 'Pain Alleviating Treatment Provided' with nine treatments listed that can be checked if used. It doesn't show up on your side unless you click on the time when a pain assessment was completed." This surveyor observed 17 pain assessments with interventions listed, only three assessments included non-pharmacological interventions. The DON was advised of the above information during a meeting with the survey team on 11/16/2016 at 4:20 p.m. No further information was received by the survey team prior to the exit conference on 11/17/2016.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having	F 314	**F 314 Treatment/Svcs to prevent/heal pressure sores (sanitary manner)** 1) Nursing staff was notified of the deficient practice on 11/17/16 with further follow-up planned at staff meetings. Resident #1 was observed for signs and symptoms of infection related to the deficient practice during the dressing change. Resident #1 has not developed any signs or symptoms of infection. 2) There were no other residents on the skilled nursing unit who may have been affected by the deficient practice.	

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F 314	Continued From page 4 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, facility staff failed to treat a pressure ulcer in a sanitary manner for one of 10 residents in the survey sample, Resident #1. RN #3 (registered nurse) failed to use proper hand hygiene, set up a clean working field, opened sterile dressing packages and placed onto an unclean working field, performed a clean dressing change with contaminated gloves and dressing supplies, and returned multi-use dressing change supplies back to the night stand while wearing contaminated gloves during a dressing change to a sacral pressure ulcer on Resident #10. Findings included: Resident #1 was admitted to the facility on 10/17/2016 with diagnoses including, but not limited to: Pancreatitis, Malnutrition, Hypoalbuminemia, Placement of a PEG tube (feeding tube), Diabetes and Congestive Heart Failure. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 10/24/2016. Resident #1 was assessed as cognitively intact with a total cognitive score of 13 out of 15. Resident #1's electronic medical record was	F 314	3) After referencing Clinical Nursing Skills & Techniques (Potter & Perry, 2014), a policy was written to provide guidelines on clean dressing changes. Nursing staff were educated on this policy on November 29 & 30, 2016. The steps of this policy include: a. Assemble needed supplies at bedside. Close room door or bedside curtains. b. Perform hand hygiene and apply gloves. c. Open sterile packages and topical solution containers. d. Remove bed linen and patient's gown to expose area to be treated. e. Remove old dressing and discard. f. Remove gloves and perform hand hygiene. Apply clean gloves. g. Cleanse wound thoroughly as prescribed. h. Apply topical agents if prescribed. i. Using a sterile cotton tipped applicator, apply a small amount of topical agent to the wound. Do not re-use soiled cotton tipped applicator for other areas of the wound or insert soiled applicator into any container. i. Apply dressing as prescribed. j. Position patient for comfort. k. Remove gloves and perform hand hygiene. 4) Starting December 5, 2016, the director of nursing or his designee will observe three pressure sore dressing changes each week, if any are present on the unit, until a total of fifteen dressing changes have been observed. If compliance with clean dressing change is not maintained after fifteen dressing changes, another round of three per week will be observed for another total of fifteen. Compliance with proper clean dressing change technique will be reported monthly at staff meetings and quarterly at the unit performance improvement committee beginning January 2017. Reference: Potter, Patricia. A. and Perry, Anne. Clinical Nursing Skills & Techniques. 8th edition. St. Louis: Mosby, Inc. 2014. **Correction date:November 30, 2016**	

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reviewed on 11/15/2016 at approximately 12:00 p.m. Physician orders included specific wound care orders. Wound care documentation included care of a sacral pressure ulcer.

On 11/16/2016 at approximately 3:40 p.m. this surveyor spoke with RN #3 regarding Resident #1's pressure ulcer. RN #3 stated, "Last night when I changed his dressing the area was heated so I left it open to air. We can go assess how the area looks now. Last night it was all dried up." RN #3, this surveyor and a federal oversight surveyor entered Resident #1's room. RN #3 informed Resident #1 why were in the room and the resident repositioned himself in the bed onto his right side. RN #3 donned a pair of clean gloves and exposed Resident #1's sacral area. The sacral area was red in the midline and out onto both buttocks. Three open areas were noted, one on the left buttock and two on the right buttock. RN #3 stated, "It has opened up again, so let me get his dressing change stuff and I will cover it back up." RN #3 covered the exposed area while she retrieved dressing change supplies from Resident #1's nightstand on the opposite side of the bed. She gathered a bottle of dermal wound cleanser, a package of 4x4's, a skin prep package, an Allevyn dressing and a box with a tube of Iodosorb ointment. She went out into the hallway to the medication cart and obtained two packages of sterile cotton swabs and returned to the bedside. RN #3 placed all the wound care supplies onto Resident #1's bedside table. She did not clean the bedside table or place a clean barrier over the table. RN #3 opened the Allevyn dressing, pulled it halfway out of the package and placed it on the bedside table. She took the Iodosorb tube out of the box, removed the lid and

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placed onto the bedside table. She opened the package of sterile 4x4's and wet them with dermal wound cleanser. She then turned to the resident, exposed his sacral area, patted the reddened areas with the dermal wound cleanser on the 4x4's, discarded the 4x4's in the bedside trash can, removed a sterile cotton swab and squeezed Iodosorb ointment onto the tip. RN #3 applied Iodosorb ointment to all three open areas using the same cotton swab, discarded the first swab, opened a second swab, applied Iodosorb ointment to the tip of the second swab and applied this to the lowest open area on the right buttock. Both swabs were discarded into the bedside trash can. RN #3 applied skin prep to the outer edges of Resident #1's sacral area, removed the Allevyn dressing from its package, removed the cover and placed the Allevyn dressing over Resident #1's sacral area. RN #3 assisted Resident #1 to remain on his right side with pillows behind his back and one between his knees, then covered the resident with his bed linens. She gathered all the dressing change supplies from the bedside table and placed them back into the drawer of the nightstand. At that time RN #3 removed the pair of gloves she donned at the start of the wound observation and used hand sanitizer. RN #3 was never observed washing her hands or using hand sanitizer during the entire wound assessment or dressing change procedure.

The DON (director of nursing) was informed of the above observation during a meeting with the survey team on 11/16/2016 at 4:20 p.m. This surveyor requested any facility policies pertaining to clean dressing change techniques during the meeting.

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On 11/17/2016 at 8:00 a.m. the DON brought this surveyor a "Hand Hygiene Policy Issued 11/95; Revised 2/02; Reviewed 8/13" and a reference used by the facility for clean dressing change techniques from "Clinical Nursing Skills & Techniques" by "Potter and Perry." The DON stated, "We use Potter and Perry. The nursing standard for dressing changes."

The "Hand Hygiene Policy" included the following: "1. Purpose: Your hands serve as the common vehicle in almost every transfer of potential pathogens...2. Policy: Hands should be cleansed routinely: Before having contact with the patient; Between every patient contact and after handling contaminated articles; After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient;...After contact with a patient's intact skin;...before donning gloves..."

"Potter and Perry" steps for "Treatment of Pressure Ulcers" page 449 included the following: "...2. Assemble supplies at bedside...3. Perform hand hygiene and apply clean gloves. Open sterile packages and topical solution containers. Keep dressings sterile...4. Remove bed linen and arrange patient's gown to expose ulcer and surrounding skin...5. Remove old dressing and discard in appropriate receptacle...Remove gloves and discard. 6. Perform hand hygiene and change gloves. 7. Clean wound thoroughly with normal saline or prescribed wound-cleansing agent from least contaminated to most contaminated area. 8. Apply topical agents to wound using cotton-tipped applicators or gauze as ordered...9. Apply prescribed wound dressing...10. Reposition patient comfortably off pressure ulcer. 11. Remove gloves and dispose

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of soiled supplies. Perform hand hygiene." (1)

No further information was received by the survey team prior to the exit conference on 11/17/2016.

(1) Potter, Patricia A. and Perry, Anne Clinical Nursing Skills & Techniques. 8th Edition St. Louis: Mosby, Inc. 2014

F 356 SS=C 483.30(e) POSTED NURSE STAFFING INFORMATION

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse

F 314

F 356 Posted nurse staffing information

1) Augusta Health acknowledges it is important that each resident knows the name of the nurse and CNA providing their care. For this reason, this information is written on the individual Care Board in each resident's room at the beginning of each shift. After the surveyor reported on 11/16/16 that the complete nurse staffing information and resident census results were not posted, the dry erase board across from the nurse's station was updated completely to comply with this regulation. Of note, the current date and the names of staff providing resident care were posted.

F 356

2) All ten residents may have been affected by not having the complete nurse staffing information posted.

3) A new dry erase board has been ordered and will be in place by 12/9/16. At the beginning of each shift, staff will update the board to reflect correct information for that shift. The current shift information is also on a paper copy in a binder at the nurses' station. Copies of these sheets are kept on file for 18 months. The dry erase board is a large visual representation of the same information on the paper copy. The dry erase board has a permanent template for completion that includes the following:

a. Facility name

b. Date

c. Current Shift

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F 356	Continued From page 9 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post the daily staffing level on the Skilled Nursing Unit, including the name of the facility, current date, number of staff and hours worked, and the current facility census. The findings were: During the General Observations tour at 2:45 p.m. on 11/16/16, there was no signage found on the nursing unit to advise residents, family members, and general public of the name of the facility, the current date, the number of licensed and certified staff (Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants) working on each shift for the current date, the hours worked, and the current census. The lack of staffing information signage was discussed with the Skilled Nursing Director and the survey team during a meeting at 4:20 p.m. on 11/16/16.	F 356	d. Total number of RN, LPN, and CNA providing resident care e. Current number of residents. 4) Starting 12/9/16 the charge nurse will monitor each shift that the current information is publicly posted on the dry erase board. She will initial on a checklist that this was completed. This checklist will continue for 45 days and will be monitored weekly by the director of nursing or his designee. **Correction date: December 9, 2016**	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, and review of facility documents, the facility staff failed to store, prepare and serve food in a sanitary manner in the main kitchen and in a small kitchen on the Skilled Nursing Unit.

A tour of the Main Kitchen and the Nursing Unit Kitchen found expired dairy items; open, undated and uncovered food items in the dry storage room, walk-in coolers and freezer; food at an incorrect temperature on the food line; personal items, including a prescription medication stored behind a coffee maker; no test strips available for both three compartment sinks; a dirty can opener; a lack of sanitation during the test of food temperatures; a food service employee without a beard guard.

The findings were:

1. The initial tour of the main kitchen was conducted beginning at approximately 10:45 a.m. on 11/15/16. The surveyor was accompanied by the Director of Food Services during the tour and the following observations were made:

A. Catering Area immediately adjacent to the Main Kitchen:

At the three compartment sink, the surveyor asked if there were any test strips for checking the chemical sanitization levels used during the wash, rinse and sanitization process. "We did

Food Storage Policy was reviewed, revised to include a daily audit tool for checking to ensure all opened bulk packages and refrigerated foods are appropriately labeled and dated "for use by" per policy. Completed 11/18/2016

Felt tip markers and stick on labels added to the kitchen prep areas so staff will have supplies available to complete the labeling and dating process. All nutritional service staff educated on process and expectation for relabeling and dating of all opened bulk food packages. Completed 11/27/2016

Nutrition Services Management staff assigned to conduct daily auditing and follow-up with immediate corrective action if compliance is not found. Implemented 11/28/2016

All Nutritional Service staff reeducated on performance expectations to secure and cover all open food items. Completed 11/27,2016

Nutritional Services Management Staff assigned to conduct daily auditing to verify all opened items are properly secured and covered–follow-up with immediate corrective action if compliance is not found. Implemented 11/28/2016

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F 371	Continued From page 11	F 371	Sanitizer Test Strips	

have (the test strips)," the Director of Food Services said, "Maybe they fell. Maybe someone took them to the Kitchen." The Director of Food Services went on to explain that although the three compartment sinks are used, anything washed in the sinks is taken and run through the dishwasher. "Maybe we should be checking the water."

On a stainless steel table in the Catering area, there was an accumulation of dried, black debris at the base of a table mounted can opener.

On a stainless steel table next to the three compartment sink was a large coffee maker along with a large, circular urn for tea. Stored behind the coffee maker were an number of personal items, including a pair of black gloves, a large soda cup, a dozen brown eggs in a clear plastic container, and a small bottle of prescription medicine labeled Erythromycin and bearing the name of an individual identified by the Director of Food Services as an employee in the Catering area.

(NOTE: Erythromycin is an antiinfective used in the treatment of mild to moderate respiratory, skin and soft tissue infections. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 453.)

At 7:45 a.m. on 11/16/16, the employee, identified as Nutrition Assistant # 2 (NA # 2), whose name appeared on the Erythromycin label, was interviewed. Asked where she works, NA # 2 said she primarily works in the dining and catering areas. When asked if the Erythromycin belonged to her, NA # 2 said, "Yes. I have psoriasis. My doctor thinks it is related to my

- Engineering installed small wall mounted container above sinks to provide easy access and storage of sanitizer test strips. Completed 11/28/2016

- Staff reeducated on proper use of the test strips and performance expectations. Completed 11/28/2016

- Management staff will verify and document on daily log that test strips are available during daily rounding activities. Implemented 11/29/2016

All staff have personal lockers and were reeducated they are to utilize them for all personal belongings. Completed 11/28/2016

Management staff will verify and document on the daily log that no personal belongings are stored in the work areas during daily rounding activities. Implemented 11/29/2016

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pregnancy and she is trying the Erythromycin to treat it." NA # 2 went on to say that the facility and the Food Services Director were aware of her condition.

Asked about the other items behind the coffee maker, NA # 2 said she didn't know who the gloves belonged to, but that the eggs belonged to another employee who brought them in to sell. Regarding the soda cup, NA # 2 said, "We aren't allowed to have them (drinks) on the floor (food preparation area), so we keep them there."

At approximately 8:00 a.m. on 11/16/16, the Food Services Director was interviewed regarding NA # 2's skin condition. The Food Services Director said he was aware of her condition, that she had been seen by the hospital's Employee Health Department, and cleared to work in her current capacity.

B. Main Kitchen area:

In the Dry Storage area, the following items were open and undated; a small bag of Trail Mix that had been repackaged by the kitchen staff, a bulk bag of Trail Mix, a bag of Whole Grain Elbow Macaroni, a bag of Corn Bread Mix.

In the first of two walk-in coolers, a container of cooked chicken was not tightly sealed. As soon as the Food Services Director touched the lid to check the date, the lid popped off.

In a walk-in freezer, there were two open bags of frozen raspberries. One bag was not dated, and the other bag, which was loosely wrapped, had a date that was not legible.

Base of can opener was cleaned of all debris. Completed 11/15/2016
Staff reeducated on the performance expectations for the cleaning of items on the daily cleaning list. Completed 11/28/2016
Verification of cleanliness of the can openers, including the base were added to the manager's daily log. Completed 11/29/2016

Employees who wish to maintain facial hair, regardless of close grooming and short length are educated on requirement to wear a beard guard while working. Failure to do so can result in corrective action. Completed 11/18/2016

Department Director will ensure sufficient supplies of beard guards are available in the department at all times. Completed 11/18/2016

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In the second walk-in cooler, there were three crates, partially filled with half pint cartons of milk. All the cartons of milk had an expiration date of 11/12/16. The crates of expired milk were adjacent to crates of milk, also half pint cartons, that were not expired and that were in use. There was no signage on the expired milk crates to indicate the milk was not to be used. "Those are set aside to return to the vendor for credit," the Food Services Director said.

Also in the cooler was a small bag of cubed, white potatoes that was not dated; and a small, rectangular pan labeled "Roasted Garlic" that was not covered or dated. There was also a rectangular pan labeled "Tomato Paste" that was covered and dated 11/13 - 4/13. Asked what 11/13 - 4/13 meant, the Food Services Director said, "I don't know."

During the tour, the surveyor and the Food Services Director passed by the food service line. The Food Services Director volunteered to check the temperatures of the food on the line. Of the approximaltely 15 food items checked, only the macaroni and cheese at 132 degrees failed to reach the appropriate temperature. The macaroni and cheese was taken off the line.

Prior to checking the food temperatures, the Food Services Director obtained an antiseptic wipe with which to clean the probe on the thermometer. After checking the temperature of approximately six or seven food items using the same wipe, the Food Services Director obtained another wipe which he used to clean the thermometer probe as he checked the rest of the food temperatures.

While the food temperatures were being

All Staff reeducated on performance expectations to maintain correct storage location for out of date dairy products; failure to comply will result in corrective action. Completed 11/28/2016.

Large DO NOT USE /EXPIRED signage securely attached to the milk crate used for of out of date dairy products (which are returned to vendor for credit). Completed 11/18/2016.

Management staff verifies DO NOT USE /EXPIRED sign is attached and crate is appropriately located in cooler (separate from current stock), verification of compliance is documented in manager's daily log. Implemented 11/18/2016

Out of temperature items on the hot service line:
Previous process was to record temperatures every 4 hours. If product was out of temperature it was discarded and replaced.
The process revised to check and record temperatures every two hours. If an item is out of temperature it will be reheated to 165 degrees for at least 15 seconds and returned to the line.
Staff trained on this new procedure and process implemented. Correction date 11/29/2016

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checked, a food service employee was observed plating food to be served. The employee, who had a short beard, was not wearing a beard guard.

C. Dish Washer Room:

A second three compartment sink was found in the Dish Washer Room. Asked if there were any test strips, the Food Services Director said there were none.

D. Following the tour of the Kitchen, the surveyor requested and received the facility's policies on food storage and personal hygiene.

Review of the "Food Storage" policy, dated 6/24/16, noted the following:

"Procedures
1. Perishable Storage
b. All food items are labeled, dated, and securely wrapped or covered.
e. Any outdated perishables will be discarded following the guidelines in the 'Leftover Food' policy. All outdated perishables awaiting vendor pickup and credit will be placed in a separate container away from the dated products and clearly marked 'OUTDATED-DO NOT USE.'

Frozen Storage
b. All food items are labeled, dated, and securely wrapped or covered."

Review of the "Nutrition Services Infection Control Policy," dated 7/14/16, noted the following:

"Procedures
1 Personal Hygiene:

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c. The hair must be restrained with either a cap or hair net...Beard nets required for beards over 1/2 inch long.
5. Food Storage:
d. Any outdated perishables will be discarded. Outdated Milk may be retained for pick up but kept in a separate area with labeled container marked 'DO NOT USE - OUTDATED PRODUCT.' "

It should be noted that the facility's policy requiring a beard net for beards over 1/2 inch long is in direct conflict with the Virginia Food Regulations which note that, "Except as provided under subsection B of this section, food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints...." The food regulation makes no allowance for the length of the beard. (Ref. Virginia Food Regulations, Part II, Article 4, 12 VAC 5-421-240 Effectiveness of hair restraints.)

2. Beginning at approximately 2:30 p.m. on 11/16/16, a General Observations tour of the nursing unit, Kitchen and Laundry was started and the following observations were made:

A. Nursing Unit Kitchen

The refrigerator in the Unit Kitchen contained an unopened carton of Imperial Thickened Dairy Drink with a use by date of 3/30/16, and a carton of Silk Soy Milk with a use by date of 6/25/16.

B. Catering Area immediately adjacent to the Main Kitchen:

At the three compartment sink area the Patient Services Manager for food services was asked

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about test strips. The Patient Services Manager said there were no test strips and added that "We really don't use the sinks that way. We send everything to the dish washer."

Behind the coffee maker located on the table next to the three compartment sink there was a soft drink cup and a carton of Silk Milk. Also behind the coffee maker was a clear plastic container holding what appeared to be personal items. NA # 3, who was with the surveyor at the time said the container had, "Random things. Stuff that doesn't need to be behind there."

C. Main Kitchen area:

The small, rectangular pan labeled "Roasted Garlic" observed on 11/15/16, was still in the walk-in cooler, not covered or dated.

The food service employee observed plating food on 11/15/16 was observed in the food preparation area. The employee, who had a short beard, was not wearing a beard guard.

D. Dish Washer Room:

While at the three compartment sink in the Dish Washer Room, the Patient Services Manager was asked about test strips. The Patient Services Manager indicated there were none at the sink area, but he was able to obtain one from a drawer in a table adjacent to the Dish Washer Room.

The Patient Services Manager took the test strip, activated the chemical feed system, and held the test strip under the sanitization chemical feed line. After about 30 seconds the Patient Services

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F 371	Continued From page 17 Manager stopped the chemical flow and then showed the strip to the surveyor. The reading on the strip reflected straight concentration of the sanitization chemical and not a reading of the diluted sanitization chemical used during the sanitization process. During a meeting with the Director of Skilled Nursing Services and the survey team at 4:20 p.m. on 11/16/16, the findings of the Kitchen and General Observation tours was discussed.	F 371		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to properly dispose of garbage and refuse, and failed to maintain the dumpster area in a manner that was free of debris. The findings were: The initial tour of the main Kitchen, which was conducted beginning at approximately 10:45 a.m. on 11/15/16, included the Dumpster/Loading Dock Area. The surveyor was accompanied by the Director of Food Services during the tour. At the Dumpster/Loading Dock area, the Food Services Director indicated there were two dumpsters, one for cardboard and the other for general waste. The general waste dumpster was missing, and the Food Services Director said it	F 372	F372 Dispose of Garbage & Refuse properly The blue trash carts did not contain surgical trash. Environmental Services Staff removed all leaves and debris which had accumulated under the base of the dumpster. **Correction date: ~~November 16, 2016~~** November 17, 2016 Environmental Services Staff reeducated on performance expectations to routinely check for and remove any items including leaves, found under or around collection containers in dumpster area. Completed 11/27/2016 Environmental Services Management will increase to daily monitoring of dumpster area to ensure compliance. Implemented 11/28/2016	

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F 372	Continued From page 18 must have just been picked up. On the ground around the metal base into which the dumpster is secured, there was an accumulation of leaves and trash, including blue, latex gloves. Also on the loading dock, immediately adjacent to the dumpster access, were two blue trash carts containing clear plastic bags. The bags were filled with blue sheets and clear, plastic oxygen equipment. The Food Services Director said the carts contained surgical trash. The findings were discussed with the Director of Skilled Nursing during a meeting with the survey team at 4:20 p.m. on 11/16/16.	F 372		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	**F 441 Infection control, prevent spread, linens (dropped med, hand hygiene)** Dropped Medications 1) The two residents involved with the dropped medications were observed since the deficiency was noted and have not shown any signs or symptoms of infection. 2) All ten residents on the unit potentially could have been affected by the deficient practice and none have shown signs or symptoms of infection. 3) After referencing Clinical Nursing Skills & Techniques (Potter & Perry, 2014), a policy was written to provide guidelines for handling dropped medications that is practicable. Nursing staff was educated on this policy on November 29 & 30, 2016. The steps of this policy include a. Perform hand hygiene prior to administering medications. b. When a medication is dropped onto the patient gown, bed/chair linen or bedside table inspect the medication with clean hands for any visible soiling. If none visible, the medication may be administered. c. When a medication is dropped onto the floor or is visibly soiled, the medication will be discarded and a new dose obtained.	

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isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on medication pass and pour observation, hand hygiene observation, staff interview and facility document review, facility staff failed to follow infection control practices on the skilled unit.

Facility staff failed to follow proper technique for dropped medications during the medication pass and pour observation and failed to perform proper hand hygiene during two separate observations.

Findings included:

A medication pass and pour observation was performed on 11/16/2016 at approximately 8:10 a.m. with LPN #1 (licensed practical nurse), this surveyor and a federal oversight surveyor.

During medication administration to the first resident a pill was dropped onto his gown. LPN

F 441 4) Augusta Health has an incident reporting system in place for staff to report variance in practice. The director of nursing will monitor the medication variance report on an ongoing basis. Any variance related to a dropped medication will be addressed with the individual employee and reported at the unit performance improvement committee beginning in January 2017.

Reference: Potter, Patricia. A. and Perry, Anne. Clinical Nursing Skills & Techniques. 8th edition. St. Louis: Mosby, Inc. 2014.

Hand Hygiene

1) Nursing staff was notified of the deficient practice on 11/17/16 with further follow-up at staff meetings. No resident was affected by the deficient hand hygiene practice of RN#3 as this observation was at the end of a resident encounter.

2) All ten residents potentially could be affected by deficient practice in hand hygiene. However, there have been zero nosocomial infections on the skilled nursing unit in the past three months.

3) The hand hygiene policy was reinforced with staff during staff meetings on November 29 & 30, 2016. Education included that alcohol hand rinse is the preferred method of hand cleansing except when hands are visibly soiled or with patients with *c. diff.* Also included in the education was reinforcement of fifteen seconds of hand washing when using soap and water and the use of paper towels to turn off faucets.

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F 441	Continued From page 20 #1 caught the pill on the resident's gown and placed back into the medication administration cup. The resident then took the pill. LPN #1 was not wearing gloves during the administration of his pills. LPN #1 applied gloves to apply eye ointment to this resident. After removal of the gloves LPN #1 went into the resident's bathroom, turned on water in the sink, wet her hands, applied soap, rubbed together for approximately five seconds, rinsed, turned off water faucets with her bare, wet hands and dried with a paper towel. During pill administration to a second resident at approximately 8:25 a.m., a pill was dropped onto the resident's bedside table. LPN #1 picked the pill up with a gloved hand and administered said pill to the resident. LPN #1 was interviewed on 11/16/2016 at approximately 10:30 a.m. by this surveyor. LPN #1 stated, "I usually wash my hands if they come in contact with bodily fluids, giving eye drops, insulin, stuff like that. Otherwise I use hand sanitizer. Normally use gloves if giving eye drops, insulin, cleaning a patient. Don't like to use gloves when opening pills. They sometimes break and a piece of the glove gets in the pills. I open packets so I don't touch the pills. If I drop a pill on the floor or somewhere I will get another one. If drops on their clothes or something I just let them take it." The DON (director of nursing) was interviewed 11/16/2016 at 1:30 p.m. The DON stated, "There is no specific policy that mentions what to do if meds are dropped. This policy, referring to "Medication Administration Definitions" just states what to do in case of med errors or missed	F 441	4) To monitor compliance with hand hygiene, thirty resident encounters spread across all three shifts will be observed by hand hygiene auditors per month on an ongoing basis. Compliance with hand hygiene policy will be reported to the director of nursing, shared in monthly staff meetings and reported to the unit performance improvement committee beginning in January 2017. **Correction date: November 30, 2016**	

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doses." Regarding his expectation for dropped medications, "Actually would depend on the scenario. If it dropped on the floor or table I would probably return it and get another one. If it dropped on their gown or clothing I probably would not get another one. Some patients have dexterity issues and I'd say it happens."

RN #3 (registered nurse) was observed washing her hands after removing gloves on 11/16/2016 at approximately 4:00 p.m. RN #3 used a motion sensored sink. She wet her hands, applied soap, rubbed approximately five seconds, rinsed and then dried with a paper towel.

The DON was informed of the above hand washing observations by this surveyor during a meeting with the survey team on 11/16/2016 at approximately 4:20 p.m. This surveyor requested a copy of the facility hand hygiene policy.

On 11/17/2016 at approximately 8:00 a.m. the DON presented a copy of the facility hand hygiene policy to this surveyor. The "Hand Hygiene Policy Issued 11/95; Revised 2/02; Reviewed 8/13" included, "1. Purpose: Your hands serve as the common vehicle in almost every transfer of potential pathogens from one patient to another...hand hygiene is the single most important measure for preventing the spread of infection...3. Procedure: Hand washing...B. Steps: 1. Wet hands with warm water and apply soap...2. Wash hands vigorously for FIFTEEN seconds...4. ...Avoid touching the sink and faucets with your hands...5. Rinse hands under running water...6. Pat hands and wrists dry with a paper towel. 7. Turn off the faucets and open door using a paper towel, to avoid re-contaminating your hands..."

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F 441	Continued From page 22 No further information was received by the survey team prior to the exit conference on 11/17/2016.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure two ice machines that produce ice for patient use, and one ice machine that produced ice for non-patient use had a drain system air gap. In the Laundry, a wall mounted circulating fan had an accumulation of lint. The findings were: During the General Observations tour at 2:30 p.m. on 11/16/17, the following was noted: 1. In the Nursing Unit Kitchen, a counter top ice machine, located next to a hand washing sink, did not have an air gap. The drain line for the ice machine was connected directly to the hand washing sink out flow line above the trap. 2. In the Main Kitchen, a full size ice machine, located on the floor near a walk-in cooler, did not have an air gap. The drain line for the condenser unit, and the drain line for the ice holding bin were laying directly on top of the floor drain. Both the Nursing Unit Kitchen ice machine and	F 456	**F456 Essential Equipment, Safe Operating Condition** 1. Skilled Nursing Kitchen ice machine drain pipe has been modified to include an air gap – completed 11/25. 2. Main Kitchen ice machine drain pipe has been modified to include an air gap - completed 11/25. 3. Main Laundry ice machine drain pipe has been modified to include an air gap - completed 11/28. 4. Main Laundry Room lint accumulation on fan screen – fan has been cleaned - corrected 11/28. The previous 12-month periodicity for reoccurring cleaning of fan screen in the laundry room has been changed to every 6 months. **Correction date: November 28,2016**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495214	A. BUILDING _____ B. WING _____	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA MEDICAL CTR SKILLED CA	78 MEDICAL CENTER DRIVE FISHERSVILLE, VA 22939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 23	F 456		

the Main Kitchen ice machine produce ice for patient use.

3. In the Laundry room, a counter top ice machine, located next to a hand washing sink, did not have an air gap. The drain line for the ice machine was connected directly to the hand washing sink out flow line above the trap. It is duly noted that the ice machine in the Laundry does not produce ice for patient use.

4. In the Laundry room, a wall mounted circulating fan, located above several laundry bins, had an accumulation of lint on the fan screen. The fan was operating at the time of the observation.

The findings were discussed with the Director of Skilled Nursing, the Director of Plant Operations, and the survey team during a meeting at 9:00 a.m. on 11/17/16.